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ABSTRACT

In April 1989, the National Institute on Drug Abuse (NIDA) convened a meeting of 17 Acquired Immune Deficiency Syndrome (AIDS) education and training experts to discuss AIDS and substance abuse training and to examine NIDA-initiated training efforts. Participants were asked to develop specific recommendations for NIDA regarding its role in providing comprehensive and systematic AIDS training to substance abuse counselors and outreach workers. Chapter I of this report sketches the format of the NIDA meeting. Chapter II gives historical context to the discussions that took place at the meeting, describing the evolution of NIDA's National Training System from its inception in the early 1970s to its dismantling in 1981. Chapter III summarizes the conference discussions and recommendations of the participants in the four areas of inquiry for the workshop: (1) developing an AIDS training plan; (2) developing an AIDS curriculum; (3) developing a system for delivering AIDS training; and (4) developing AIDS trainers. For each topic, the chapter reviews the status of knowledge and practice, identifies gaps and needs, suggests approaches for evaluation, and offers recommendations for improvement. Chapter IV notes the three major themes that surfaced during the meeting: (1) the need to professionalize the chemical dependency work force; (2) federal-state partnerships; and (3) the maturing of the training leadership. The chapter also discusses NIDA's AIDS activities in such areas as training development, supervision, sensitivity to youth and minorities, and cooperation with state efforts. A list of meeting participants, including their addresses and telephone numbers, is appended. (NB)

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Training Drug Treatment Staff In The Age of AIDS

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Training Drug Treatment Staff In The Age of AIDS: A Frontline Perspective

Clinical Report Series

Editor:
Rebecca S. Ashery, D.S.W.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, Mental Health Administration

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TABLE OF CONTENTS

	Page
Preface	v
Chapter I: Introduction	1
Chapter II: The National Training System--A Historical Perspective	3
Chapter III: Training in the Age of AIDS	7
Chapter IV: Emergent Themes and NIDA Activities	29
Appendix A: List of Participants	33

PREFACE

In 1973, the National Institute on Drug Abuse (NIDA) was formed as the Federal Government's lead agency in the effort to confront drug abuse through coordinating and supporting research, prevention, treatment, and rehabilitation. Since then, NIDA has continued aggressively to provide leadership and resources throughout the substance abuse field.

In more recent years, a new challenge has arisen: acquired immune deficiency syndrome (AIDS). Substance abuse programs are in the forefront of the crucial battle to stem the AIDS pandemic because they provide services for the high-risk drug-abusing population. This fact has brought into focus a new priority: the training substance abuse professionals need to provide their clients with appropriate, accurate AIDS education in a sensitive manner. These workers often need training in counseling and other related skills that are prerequisites for providing effective treatment.

Recognizing its critical responsibility to facilitate the massive AIDS training effort required, NIDA convened an AIDS educators meeting on "Training in the Age of AIDS" in April 1989. The purpose of the conference was to survey the status of AIDS training and determine where the gaps are, what needs to be done, and how to evaluate current and future efforts.

NIDA is pleased to publish this report summarizing the participants' discussions and recommendations and hopes that this publication will stimulate concerted action in the continuing effort to provide substance abuse professionals with the AIDS training they need.

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CHAPTER I: INTRODUCTION

In April 1989, the National Institute on Drug Abuse (NIDA) convened a 2 1/2-day meeting of educators to discuss acquired immune deficiency syndrome (AIDS) and substance abuse training and to examine the NIDA-initiated training efforts in the "age of AIDS." In particular, participants were asked to develop specific recommendations for NIDA regarding its role in providing comprehensive and systematic AIDS training to substance abuse counselors and outreach workers.

MEETING PARTICIPANTS

The meeting brought together 17 AIDS education and training experts in a collegial forum. To provide for a broad range of perceptions, problems, and issues, NIDA selected participants who had experience with diverse cultures and who represented all regions of the United States, States with high and low incidences of human immunodeficiency virus (HIV) infection, and all levels of government (national, State, and local).

CONFERENCE FORMAT

Through small- and large-group discussions, the participants were asked to focus on four key training topics: (1) developing an AIDS training plan, (2) developing an AIDS curriculum, (3) developing a system for delivering AIDS training, and (4) developing AIDS trainers. Participants examined each topic in relationship to the following questions: (1) What is different about training in the age of AIDS? (2) What is the current status of NIDA-initiated AIDS training? (3) Where are the gaps? and (4) What recommendations can be made concerning the gaps?

Chapter II of this report gives historical context to these discussions, describing the evolution of NIDA's National Training System from its inception in the early 1970s to its dismantling in 1981. Chapter III summarizes the conference discussions. Chapter IV notes the themes that surfaced during the meeting and discusses NIDA's AIDS activities.

A list of the AIDS education and training experts who attended the meeting, including their addresses and telephone numbers, is in appendix A.

CHAPTER II: THE NATIONAL TRAINING SYSTEM--A HISTORICAL PERSPECTIVE

The perception that drug abuse and drug addiction warrant intervention and treatment is relatively new. Until 1966, the use of illicit substances was widely regarded as an immoral choice that merited punitive treatment, including criminal incarceration. During the late 1950s and early 1960s, the incidence of drug abuse increased substantially, however, causing the Federal Government to declare in 1966 that addiction was a disease and a "national problem." This official change of attitude prompted a parallel shift in public opinion. The stigma attached to substance abuse and addiction gave way to a more humane emphasis on treatment for and rehabilitation of afflicted persons.

In developing programs of treatment and rehabilitation for the growing number of drug-dependent people, the Federal Government faced the immediate problem of finding qualified staff. Specialists in the field did not exist. Compelled by public pressure to institute treatment programs quickly, the Government chose a solution that was unprecedented in the history of health care delivery. Ex-addicts, without the benefit of formal training, became the administrators and counselors for the newly established drug treatment facilities. Trained staff, including psychologists, social workers, doctors, and nurses, provided the necessary professional backup.

This approach had its advantages: It provided a ready source of workers who could offer treatment services on the basis of personal experience. But as ex-addicts, the new treatment staff frequently identified too closely with clients' experiences and were unable to remain objective.

It soon became evident that counselors needed knowledge and skills to enhance their personal experience and formal education to meet State credentialing requirements and to qualify for promotion within the field and lateral movement into related health areas. This need to professionalize treatment staff prompted many efforts to provide formal education and training--efforts that coalesced in 1973 with the establishment of NIDA.

A NATIONAL TRAINING SYSTEM

NIDA was formed as the primary Federal agency charged with coordinating drug abuse research, prevention, treatment, and rehabilitation. NIDA assumed responsibility for orchestrating development and training efforts to prepare treatment staff to meet the needs of addicts and drug abusers and, consequently, was given responsibility for a number of training programs that had already been started under the auspices of other Federal agencies.

NIDA began immediately to integrate all federally funded substance abuse training into a National Training System (NTS) under the Division of Resource Development, giving the Manpower and Training Branch specific responsibility for training. The underlying reasons for developing a systematic, coordinated approach to training were clear: to unify training efforts across the country, to clarify the language evolving from this new field of treatment, to facilitate the exchange of information about training principles and practices, and to find cost-effective ways of using limited budgetary resources. Most important, NIDA recognized, was the need to attain a higher quality of care and services for clients.

THE NTS TRAINING TARGET

NTS's mission was an enormous responsibility. In 1977, approximately 40,500 staff members provided drug abuse services to more than 234,000 drug-dependent clients. NTS had to provide specialized training and development to a very broad range of personnel: health workers with experience-based training (primarily ex-addicts), health professionals (physicians, nurses, psychiatrists, etc.), counselors, vocational and employment specialists, pharmacists, researchers, legislators and policymakers, and program managers and administrators.

The National Drug Abuse Center (NDAC) functioned as the hub of NTS. Its primary mission was to work at a national level to facilitate technology transfer. NDAC interacted with State and other organizations, agencies, and groups to obtain information and then transferred that information through training program designs and related resources. Transfer was not only from the national level to the local level but also from local programs to other local programs and States. For example, a program developed to train personnel in a Southwestern community to meet the needs of drug-abusing Native Americans could be modified by NDAC, in cooperation with the program's staff, for distribution to other States with Native American populations. These States in turn could present the training or disseminate the curriculum to local programs.

To support, extend, and complement the role of NDAC, NTS established five Regional Support Centers located across the country. Their mission was to facilitate direct training activities for State and local program personnel and maintain a nationwide exchange of information on current data and proven intervention strategies.

In addition, through the State Training Support Programs within NTS, NIDA provided direct financial support to States to develop their own training capabilities.

NTS functioned successfully as a training and personnel development system at the Federal, State, and local levels. It assisted both drug abusers and treatment personnel. In 1981, however, it was dismantled. The Federal Government would no longer act as a

broker of training. Block grants, which gave States wide latitude in determining how dollars were spent, replaced categorical grants to States, including Federal money earmarked for training.

Because of funding shortages, States deemphasized training. Most States continued to offer several training workshops a year or summer institute courses, but only a handful continued comprehensive and systematic training efforts. Therefore, when the AIDS epidemic appeared, few States were prepared to deliver appropriate training to drug treatment staff.

With this new epidemic, NIDA has again taken the lead in training. Intravenous drug users (IVDUs) are at high risk of HIV infection, a fact that adds entirely new and challenging dimensions to the work of substance abuse professionals. NIDA is addressing the new training needs by developing courses, certifying trainers, and delivering technical assistance. The participants at the meeting described in this monograph examined the issues of training in the age of AIDS and made recommendations to enhance NIDA's training program.

CHAPTER III: TRAINING IN THE AGE OF AIDS

AIDS will continue to have a profound effect on substance abuse treatment and prevention, and the challenge for substance abuse training is great. Discussion throughout the meeting revealed that AIDS has exposed the limitations of training delivery systems throughout the country. Participants acknowledged that AIDS has irreversibly changed the substance abuse field--its systems, models, and assumptions regarding health care, chemical dependency, treatment, and prevention. Participants recognized that what was believed adequate for training in the past needs rethinking in the age of AIDS.

This chapter summarizes the discussion and recommendations of the participants in the four areas of inquiry for the workshop:

1. Developing an AIDS training plan
2. Developing an AIDS curriculum
3. Developing a system for delivering AIDS training
4. Developing AIDS trainers

For each topic, the chapter reviews the status of knowledge and practice, identifies gaps and needs, suggests approaches for evaluation, and offers recommendations for improvement.

1. DEVELOPING AN AIDS TRAINING PLAN

The term "capacity building" describes the kinds of agenda and issues that emerged when participants discussed State plans for AIDS training. Although critical gaps in planning exist, the topic elicited energetic discussions of new kinds of trainers, new target populations of trainees, new skills required, and new community alliances and interagency collaborations concerning resources, personnel, and expertise.

Status of State Plan Development

In 1988, an informal survey by NIDA revealed that just six States had developed comprehensive and systematic plans to train substance abuse professionals in AIDS. This inquiry also showed that States had little information on the number, quality, level, and type of AIDS courses conducted.

The six States with AIDS training plans were the only States with non-AIDS training plans in substance abuse; this finding reflects an overall shrinkage of the national training capability in substance abuse in the past decade.

Responding to the urgent need for AIDS training and the need to direct limited AIDS training dollars efficiently, NIDA has provided the impetus for the State Substance Abuse Authorities--or single State agencies (SSAs), as they were originally called--to develop AIDS planning capabilities. Acting through The Center for AIDS and Substance Abuse Training (The Center), NIDA requires each State to submit a completed AIDS training plan as a condition of receiving NIDA-sponsored courses and offers technical assistance to help States develop these plans. So far, 30 States have submitted plans.

Each plan must have the following components, which are described in a detailed instrument available from The Center. The instrument provides worksheets and suggestions for completing each planning step.

- *Statement of the Problem.* This statement describes the State's AIDS issues, identifies problems in the State's program for substance abuse treatment and gauges their prevalence, lists the problems that are amenable to training solutions, and, ideally, includes a statement of the philosophy and mission that underlie the State's plan and drive its distribution of resources and accountabilities.
- *Identification of Training Needs and Priorities.* The State conducts a needs assessment to define training needs and priorities based on problems such as lack of knowledge, motivation, sensitivity, or skills.
- *Identification of Training Resources.* Resources include curriculums, trainers, facilities, training funds, and expertise to provide support. Regional, State, and local resources, both public and private, may be available. The State needs to ascertain the availability of resources to meet training needs and determine what resources are lacking or require further development.
- *Action Plan for Development and Delivery of Training.* This plan specifies training goals and measurable objectives; identifies forces that impede and forces that promote goal attainment; and determines action steps, assignments, timetables, and review procedures.

During the meeting, the discussion reflected three main concerns related to planning: the need for (1) systematic and comprehensive training approaches, (2) client-based needs assessments, and (3) sustained commitment to financial support.

Systematic and Comprehensive Training Approaches

Participants experienced in State training plans advocated a systematic and comprehensive approach to training development instead of a crisis response. Despite the

urgent need for training, State and local leadership must develop training plans that add courses systematically and build rationally on skills that counselors already possess.

A comprehensive training program meets the training needs of all substance abuse workers in a State, according to job function, prior training, and HIV prevalence in the client population. A comprehensive program addresses the different information and skill needs of secretaries, janitors, kitchen staff, counselors, supervisors, and managers. For example, staff counselors need specific training in communicating facts about HIV transmission and in conducting risk assessments with clients, whereas program administrators require information and resources pertaining to the medical services needed by HIV-infected clients.

In a systematic plan, courses and modules build upon each other to increase trainees' competence and mastery. Areas such as risk assessment and risk reduction counseling, HIV test counseling, and case management of the HIV-positive client involve information and skills that range from simple to complex, and training should be geared to increasing levels of proficiency and mastery.

Client-Based Needs Assessment

Participants considered a client-based approach to needs assessment critical to an effective AIDS plan, concurring that needs assessment should avoid a formal approach in which planning is driven largely by epidemiological analysis or by some generic "menu" of AIDS training courses. Specifically, participants recommended a client-focused training approach that determines program needs and problems by asking counselors directly. This approach has two possible emphases: a needs focus or a problem focus.

When surveyed about what they think they need, counselors tend to rank courses on death and dying first, even in cities or towns where diagnosed AIDS clients have not yet been treated in substance abuse programs. This kind of response is driven more by the prevailing fashion of AIDS training rather than by counselors' day-to-day work with clients.

A needs assessment focused on problems identifies difficulties that counselors are experiencing with clients and that administrators are experiencing with staff or the community. With this approach, States can avoid blindly replicating available training packages and instead tailor existing material to meet local treatment needs.

Sustained Financial Support

Sustained commitment to securing financial support for training is critical. Effective implementation of an AIDS training program depends on the SSA aggressively staking a

claim for State AIDS monies. A State constituency for training dollars is needed, and policymakers and budgetmakers must hear this voice early and continually.

Needs and Gaps in State Plan Development

Most participants reported that developing a State training plan was problematic. Several factors hinder this process.

First and foremost, participants acknowledged that planning expertise for substance abuse training has been reduced to a nominal presence in SSAs. Although most State organizations identify staff responsibilities for State training plans, only with the recent planning push from NIDA have systematic and comprehensive plans begun to evolve. Few State staff have training as their only responsibility. Thus, the experienced work force required to generate responsive AIDS training plans was not in place when the crisis was recognized.

Moreover, SSA staff are unfamiliar with professionals and subject experts with whom they could collaborate to develop AIDS training plans. The technical and content expertise required for a comprehensive AIDS plan comes from medical, public health, and human services disciplines that study epidemiology, sex education, and pharmacology, as well as grief, death, and dying. Substance abuse personnel have not collaborated with these disciplines before and are being challenged under conditions of crisis to forge new partnerships.

Second, organizational accountability for AIDS training typically is distributed across various State agencies and is diffused through separate offices with uncertain authority for AIDS training and planning. Training funds may come from Federal sources (e.g., the Centers for Disease Control or the Health Resources Services Administration) or from the State's public health agencies (e.g., programs targeting sexually transmitted diseases, AIDS offices, minority health programs, or substance abuse programs). This diffusion of training funds and training responsibilities makes it difficult for SSAs to identify and commit resources to develop powerful AIDS training plans.

Third, there is widespread uncertainty about the level of basic skills that drug abuse counselors are bringing to the AIDS crisis. Participants reported a vacuum of substance abuse training in the field. Today's counselor is essentially unknown, with unknown training background, needs, and competencies.

Fourth, the rapidity with which HIV is spreading in some populations renders any training plan outdated as soon as it is implemented. The needs of direct service providers seem always to be one step ahead of planners and curriculum design experts. (One participant cited the example of training on risk reduction counseling, occurring after

clients had already begun to die from AIDS.) Therefore, participants emphasized the need for an evolving plan that responds to continually updated information.

Finally, experienced and available trainers are not found easily. Participants recognized that the senior drug abuse clinicians who carried a substantial portion of the training effort in the 1970s have since left the field. States are now looking to university-based training programs, to medical and health education professionals, and to trainers from a wide range of social service and human resource programs. Although most of these new trainers lack background in substance abuse programs, participants were optimistic that with the implementation of Federal and State credential programs, AIDS was "opening doors" that could advance the art of drug abuse training.

Participants identified two populations that tend not to be targeted in AIDS training plans: (1) outreach and prevention workers and (2) staff working with alcoholics and populations using non-intravenous drugs. Participants believed that these groups do need AIDS training because any drug use should be seen as increasing the probability of HIV exposure.

Evaluation of State Plans

NIDA's survey and The Center's request for training plans constitute the first broad assessment of States' AIDS planning efforts. State-level evaluations have been limited to descriptive efforts to count the numbers of trainings delivered, the numbers of drug abuse professionals trained, and the numbers of trainers trained. Statewide and regional dissemination following Training of Instructors (TOI) has been examined, also. Beyond descriptive reporting, there is a need to determine whether the resources spent on AIDS and substance abuse training are used effectively.

Participants identified a variety of areas in which a training plan can be evaluated:

- Interagency collaboration and linkages
- Statewide dissemination and saturation
- Organizational development at the SSA, regional, and local levels
- Comprehensiveness and systematic course progression
- Impact on counselors' knowledge and skills
- Impact on counselors' performance

- Impact on counselors' career development and job satisfaction
- Impact on clients

Given the range of possible areas of evaluation, evaluators need to focus their assessments in the context of each State's planning and development requirements.

Participants suggested that specific indicators of training outcome are not the only indexes of the effectiveness of planning. Additional indexes include continuing success of the SSA in garnering State and Federal training dollars and generous, unbiased media coverage of AIDS and substance abuse issues in the State.

Recommendations for State Plan Development

Participants made the following recommendations regarding AIDS training plans:

- Sustained Federal and State funding for substance abuse training, development, and implementation is critical if treatment staff are to be prepared throughout the next decade for the task of AIDS prevention and intervention in the drug-using population. Training budgets should provide for
 - A Director of Training in the SSA office, with an annual salary of \$40,000 to \$60,000 (senior management level)
 - Adequate staff and consultant trainers to support training and development of personnel
- State offices receiving AIDS funds should undertake collaborative interagency initiatives within their State to strengthen AIDS training programs. Formulas for cost and resource sharing and for teaming are needed to support the development and implementation of States' AIDS training plans.
- AIDS training plans need to be real, not "paper" plans developed merely to comply with State or Federal requirements. Real plans, prepared in collaboration with treatment programs, must be designed to correct staff deficiencies at the point of service delivery and to ensure continued development and motivation of frontline workers in the fight against AIDS.
- States should use incentives and rewards to support participation by program staff in AIDS training programs. For example, agency funding tied to attendance at training sessions, AIDS certification requirements, and routine availability of continuing education credits can encourage attendance at training.

2. DEVELOPING AN AIDS CURRICULUM

The AIDS epidemic severely challenges the limitations of previously developed training curriculums. Many assumptions regarding training content and method and capabilities of treatment and prevention staff have had to be rethought and revised.

Status of AIDS Curriculum Development

The demand for training curriculums in AIDS and substance abuse is great, and will increase as the epidemic spreads. Conference participants described many training initiatives undertaken in recent years. Most curriculums appear to be variations of generic "AIDS 101" courses developed by a broad spectrum of health care providers, educators, and community service organizations.

In the early years of the AIDS epidemic, the drug abuse community was slow to take action. Participants described the early to mid-1980s as a time of casual borrowing of bits and pieces of AIDS-related material from health centers, gay and lesbian services programs, magazine articles, and other drug abuse programs. HIV hit the large urban treatment programs long before they were able or willing to recognize the problem. The epidemic had advanced significantly before the Nation's drug treatment system began to respond effectively.

In 1985, NIDA initiated the project that has set many standards for AIDS curriculums across the country. AIDS and the IV Drug User was pilot-tested in 1986 and then expanded and developed through feedback from trainees (counselors and administrators), consultants, Federal officials, and trainers throughout the country.

By April 1990, 33 States had sponsored the NIDA cornerstone course and approximately 20,000 workers and administrators had been trained in some part of the NIDA curriculum. However, States' efforts were still uneven. Many training workshops were being delivered in short, half-day or day-long panel formats, a far cry from comprehensive and systematic training. Many States, especially those with a low incidence of AIDS, relied for curriculums and training on providers from outside the drug treatment community, such as the State health department. Meeting participants believed this unevenness is a long-term result of the dismantling of the NTS in the early 1980s.

The NIDA curriculum has evolved over the past 3 years and now comprises 30 courses of varying lengths. The specialized courses build on the methods, skills, and knowledge base of the core course. The current courses are organized into the following four major sets:

- *Preventing AIDS among Substance Abusers.* This set includes two cornerstone courses, one for administrators and one for counselors of substance abuse programs.
- *Substance Abuse Counseling in the Age of AIDS.* Nine advanced modules build on the introductory prevention course for counselors and address special AIDS-related counseling issues: Dying and Death; Group Support; Family Counseling; Treatment Planning for the HIV-Infected Client; Risk Reduction Counseling; Antibody Test Counseling; Human Sexuality; Issues for Gay, Lesbian, and Bisexual Clients; and Focus on Women.
- *Preventing AIDS in the IV Drug-Using Community: An Orientation to Community Health Outreach.* This introductory course is for workers in community outreach programs.
- *Preventing AIDS in Special Populations.* These basic prevention courses for drug abuse workers focus on the special circumstances of adolescents engaging in high-risk behaviors and of drug users and their sexual partners in the black and Hispanic communities.

Most NIDA courses target personnel in substance abuse programs, with some special courses for program managers, outreach workers, and youth workers. Several courses (e.g., Risk Reduction Counseling) have as prerequisites other NIDA courses or related training.

Each of NIDA's courses has manuals for trainers and trainees, a feature that meeting participants said was critical.

- *Trainer's Guide.* The Trainer's Guide includes a detailed, step-by-step outline on preparation and delivery, background text, skill-enhancing exercises, copies of visual aids, and a workshop evaluation form.
- *Participant's Manual.* The Participant's Manual includes informational outlines, worksheets, and readings to enhance learning and serve as the core of a personalized reference resource for use on the job.

The TOI Model

To assure dissemination of the AIDS training curriculum throughout the States, NIDA built its curriculum on the TOI model, a technology transfer approach. The three stages of the training sequence for each course are as follows:

- *Stage One.* Each State identifies a cadre of potential trainers who have basic training skills, experience in chemical dependency services or AIDS education, and special sensitivity to the subject matter. These candidates may be counselors, other staff, or consultants.
- *Stage Two.* Candidates first participate in the training workshop and observe the "model" of the master trainer delivering a course. After observing the course delivery by a master trainer, the candidates are taught how to deliver the course. During the training, they must demonstrate their competence to deliver the course. On satisfactory completion of the training, they are certified by NIDA as instructors for the course.
- *Stage Three.* Certified instructors are expected to train other drug abuse workers and administrators throughout their States according to the States' AIDS training plans. In addition, some States have conducted their own TOIs to replace instructors who have left or to increase the number of instructors.

Note that NIDA does not certify staff as general trainers. The TOI certification is always tied to a specific course. As new courses are developed, trainers are certified to teach these courses.

This TOI process can be highly effective and can reduce dramatically the time required to train an entire drug treatment work force. Active dissemination following Stage Two training and State funds to support the continued training are critical to the model's effectiveness and need to be identified in any State training plan incorporating the TOI model.

The Center for AIDS and Substance Abuse Training

NIDA's training resources are disseminated through The Center for AIDS and Substance Abuse Training, a NIDA-contracted project designed to serve the national drug abuse effort in the fight against the spread of HIV. The Center is mandated to keep NIDA's AIDS curriculum and materials current, issue new courses, identify and train a core consultant staff of master trainers, and implement AIDS training at the request of SSAs or regional drug abuse programs. Copies of the training curriculum are also available for purchase.

Currently, the Center is undertaking two major initiatives: (1) a technical assistance program to support SSAs in developing AIDS training plans and (2) development of a trainer certification process, including certification guidelines, criteria for levels of trainer mastery, and training and certification of a national core of trainers proficient in conducting all NIDA courses.

The comprehensive NIDA curriculum has set a standard for AIDS training throughout the country. It represents a vast Federal effort to build a national AIDS training capability to transfer technology and to support States in building their own training resources.

Needs and Gaps in AIDS Curriculum Development

AIDS curriculum development will be an ongoing process. The success of many national, State, and local efforts demonstrates what works and what will be needed in the next stages of curriculum development. Participants discussed a wide range of curriculum issues, including objectives; training methods and approaches; packaging, delivery, and dissemination; trainee populations; and special content areas.

In discussing curriculum objectives and methods, participants stressed the need to balance cognitive, attitudinal, and skill-based learning. Although grounding in basic knowledge is always needed, emphasis on experiential and attitudinal content is critical to counter the continuing prevalence of informational curriculums to address the continuing negative social responses to AIDS, and to meet the needs created by the expanded role of workers.

Participants emphasized practical counseling skills, needed in direct work with drug abuse clients. Substantive input and feedback from counselors should help keep training responsive to the real problems and needs of workers in local communities. Moreover, intentional, systematic repetition and reinforcement should be employed in each unit of a course, and in each course within a sequence of courses.

Concerns regarding delivery of AIDS curriculums focused on the value of team training. Two- and three-member teams are particularly effective for conducting the small-group exercises that support attitude exploration and skill building.

Participants believed that certain AIDS-related issues need to be addressed more fully and carefully in future efforts in curriculum design. Counseling clients in human sexuality and sexual decisionmaking is an important component of the counselor's role in the age of AIDS, so counselors need to be sensitized to and feel comfortable talking about sexual issues. A group counseling model might best support exploration of sexual issues with clients. In the group approach, the counselor would function as a trained facilitator rather than a sex counselor. Skills needed for this role could be acquired in intensive weekend workshops, equipping counselors to assist clients compassionately in exploring their sexual options and reducing their risk of HIV infection.

Improvements need to be made in the training of directors and supervisors, whose AIDS training needs are still not addressed adequately in many State programs. First, too

few courses are directed to the needs of these staff. Second, many directors and supervisors do not use training effectively. Some managers use the immersion approach, attending all trainings, even workshops that are clearly directed to staff counselors. Other directors and supervisors send representatives, who often lack essential training skills but are expected to report back and transmit essential knowledge. In either case, the manager does not receive appropriate training.

Training that addresses the needs of program administrators needs to be developed and disseminated, amplifying the NIDA course for administrative planning. Treating HIV-positive and -symptomatic clients requires policy decisions and a formal protocol to address recordkeeping, confidentiality, and termination of treatment; counselor morale and support; homebound clients; and the special issues regarding methadone maintenance for HIV-positive clients.

Ethical and moral issues need more attention in AIDS curriculums. Conflicts of confidentiality laws versus "duty to warn" and contact tracing are increasing. These conflicts need to be explored directly in training.

Also, training must address the conflict and denial that drug abuse counselors experience. Counselors who fear working with infected clients may make inappropriate referrals ("dumping"). Counselors without appropriate knowledge may not be able to recognize symptoms such as AIDS dementia, thinking that such symptoms are drug sequelae. At times, counseling staff have had problems with antibody testing, not knowing how to handle the client's stress or where to find appropriate treatment.

Evaluation of AIDS Curriculums

Curricular assessment has always been difficult. It is nearly impossible to evaluate a curriculum in isolation from the entire training delivery process, which includes the trainers and the training environment. Moreover, there are three basic questions regarding effectiveness: (1) Have trainees learned what was taught? (2) Have trainees integrated on a professional level what they learned? (3) Has the training had any impact on clients? These questions are rarely addressed comprehensively, if at all.

Participants were familiar with the conventional pretests and posttests that measure retention and learning, and with the posttraining assessments that rate the trainees' satisfaction and training applicability and the trainer's effectiveness. They agreed that more questions on attitudinal change should be included. Two- to 3-month followup surveys that test for retention and application would help improve training and eliminate ineffective materials.

Recommendations for Developing AIDS Curriculums

Participants' recommendations for curriculum tended to be at the systems level.

- AIDS training should be integrated into the routine training of substance abuse personnel.
- Managers and program directors must be included in specialized basic AIDS training to support counselors in their application of AIDS training skills and techniques and to ensure consistency between program policies and AIDS counseling practice.
- Curriculums need to incorporate and reinstitute group counseling in the service of AIDS risk reduction and peer support.
- A comprehensive, systematic national curriculum needs to be designed and developed. This curriculum would build upon the current core of NIDA courses, adding specialized courses developed in the SSAs and designed to be integrated into the national plan.

3. DEVELOPING A SYSTEM FOR DELIVERING AIDS TRAINING

Participants recognized that what was adequate for State training in the past may not continue to be so in the future. The stakes are much higher. Staff of substance abuse programs must be prepared to respond more effectively not only to the complex issues of chemical dependency but also to AIDS. Treatment and prevention staff need current information, skill development, and new models for intervention to help them integrate AIDS into their programs and modify their programs to meet the new demands.

Status of the States' AIDS Training Systems

In the 15 States represented by conference participants, the development of AIDS training capability varied widely, reflecting the diversity and unevenness of States generally.

The unevenness in AIDS training at the State level is a result of the interplay of many factors. Most obvious, the HIV epidemic has confronted each State's treatment system differently. The challenge in epicenter States has been enormous, forcing massive responses without time for developing systematic and comprehensive delivery models and training curriculums. SSAs in low-incidence States have not experienced the same pressures to train staff intensively, so in some areas of the country, frontline substance abuse counselors and managers have had only the most basic exposure to AIDS information, and skill development training is not yet under way.

The fate of State training organizations varied widely following the dismantling of NTS. A few States, after a period of budgetary and organizational foundering, began to redesign State trainer systems based on local, professionally self-sustaining markets of trainers. The SSA training infrastructure in these States tends to be in a position to take advantage of NIDA's new training resources.

In many States, however, the training function atrophied to the status of a paper program only. Training of frontline substance abuse workers was reduced to annual 1-day workshops or weeklong summer institutes for selected personnel. Development of AIDS-competent training staffs and training delivery systems will take longer in these States and will require new organizational and budgetary commitments.

Characteristics Critical to Training Systems Success

Participants identified several characteristics critical to the success of AIDS training systems:

- *Dedicated Staffing and Management of the SSA Training Function.* Participants agreed that for training to be implemented effectively, staff with sole responsibility for AIDS training are essential. At least two full-time trainers, certified to provide the NIDA TOI courses, should be the minimum training staff for each State. Training programs that are staffed, supported, and managed directly by SSA personnel tend to be responsive to the needs of local and regional treatment programs and to the cultural makeup of clients and staff. If an SSA amplifies its training capability by linkages with academic and continuing education programs at local universities or regional institutes, the SSA training director needs to manage these external services so that philosophy, content, and cultural responsiveness are congruent with the SSA training plan.
- *Federal Support of States through NIDA Curriculum Design and Standards Setting.* The emerging training model for AIDS and substance abuse involves the critical national leadership and technology transfer functions performed by NIDA. The vast majority of States do not have the human and technical resources to design and test AIDS curriculums, develop training delivery models, implement statewide staff training, and upgrade and certify program staff. These tasks need to be distributed appropriately among the national, State, regional, and local levels. A national perspective on training and a coordinated, comprehensive approach are essential. NIDA is providing a strong foundation of curriculums, certification standards, training manuals, and trainer development. With this foundation, individual States can focus efforts on delivery of training, certification of all program staff, and curriculum modifications and additions, as appropriate.

- *Proactive State Ownership of AIDS Training Programs.* At the State and local levels, the major concern is to define the nature and scope of training required. Proactive planning and advocacy for State training budgets are necessary. Private or public training centers at regional and State levels need to develop strategies to provide courses to a wide range of workers from various systems or focus on indepth training for particular systems. State training programs should integrate national courses into curriculums developed specifically to meet the needs of the individual States.
- *Dissemination and Technology Transfer Linked to Certification.* With the increased availability of certification-based training at the State level, there will be increasing demand for States to implement AIDS certification programs for all treatment personnel and to assure dissemination of this certification-based training statewide through the TOI approach.

Needs and Gaps in Training Delivery Systems

Two issues--cost containment and trainee selection--have particular impact on training efficiency.

Cost-containment strategies for State-initiated training need to be identified. Participants discussed two important areas in which they believed costs could be contained and savings generated: release time for staff training and computer-based technology for updating and disseminating materials.

Programs have trouble scheduling release time for both trainers and staff. When travel expenditures are added to the costs of release time, the financial commitment to staff training often becomes burdensome. One way to reduce costs is to hold training onsite. Most programs set aside certain hours for staff development purposes, and these hours can be used for AIDS training. Not only does onsite training encourage maximum staff participation, it assures that training occurs in the relaxed, receptive, and familiar program setting. Small proximate programs could sponsor special training courses jointly. It is far easier and less costly for a program to shut down for a few hours than to send staff to a central location for training.

Also, computer-based technology needs to be applied to training. The conventional mode of printing, storing, and shipping training materials is very costly, and the cost is compounded when materials are revised extensively. Instead, States could form a network for computer-assisted development of training products. The diversity of AIDS training delivery and the constant change in technical and demographic information will require manuals with interchangeable modules and an electronic bulletin board where incoming AIDS information can be posted daily. Interchangeable modules would enable the AIDS

trainer to upscale, downscale, and reorganize a manual efficiently to meet the specific needs of an upcoming event. Through a bulletin board, the trainer can access information to update any of the selected modules. Any updates can be downloaded, integrated into the text, and printed as hard copy. In less than an hour, an updated copy can be ready for printing. The use of modern computer-assisted technology to develop and maintain materials will achieve great cost savings for the States.

Trainee selection involves factors related to job function, prior training, and HIV prevalence in the client population. It is unquestioned that all persons working in substance abuse programs, including secretarial, janitorial, and other support staff, as well as counselors, supervisors, and managers, need training in the age of AIDS. However, not all need the same training. A program administrator may have concerns regarding the increased demands placed on clinic medical services because of HIV infection, whereas the line staff need training in delivering risk reduction messages. It would be difficult to incorporate both topics within a single course, or within a single training workshop, although both are valid training topics.

States need to identify all regional and local AIDS training resources outside the substance abuse system and utilize these resources whenever possible. However, outside courses need to be investigated to assure that they are appropriate for workers in chemical dependency.

Evaluation of Training Delivery Systems

A comprehensive evaluation of a training system would, in fact, constitute an evaluation of the training plan, insofar as this plan encompasses all the goals, structural components, tasks, activities, and resource allocations in the State training system. For the most part, State training offices use a more limited and practical approach to system evaluation, examining such components as trainer and curriculum effectiveness, staff and program input, and dissemination.

Most States conduct routine pretest and posttest evaluations of their AIDS curriculums and training sessions. Some use more elaborate followup interviews with trainees, especially when pilot-testing new courses. Several participants reported that the SSA office queries treatment programs about additional training needs, applications of prior trainings, and program policy or staffing changes made as a result of past trainings.

Some participants expressed the opinion that evaluation instruments should be standardized. As in other training areas that undergo a high degree of change, there is a tendency to change the evaluation instrument continually, in the hope that better data will have a stabilizing effect on design. Although such actions may provide some sense of comfort, they make things worse. The change that characterizes today's AIDS training

requires highly standardized benchmarks to make effective evaluation possible. The standardized course evaluation developed by NTS's Central Regional Support Center (CRSC) provides such a benchmark. This instrument includes the following components:

- Participant's responses: Likert scale ratings and comments on
 - Course design
 - Course delivery
 - Course materials
 - Facility
 - Trainers
- Participant's learning gains: Measured by multiple-choice responses on
 - Pretest
 - Posttest

Clearly, the use of a single design for several years would provide a sound base for comparing AIDS training with other substance abuse training. However, the CRSC evaluation design does not address job usefulness and lacks client followup information to determine whether staff are applying their newly acquired skills.

Where State training offices take evaluation seriously--making indicated modifications and giving feedback to trainees and trainers--demand for additional trainings tends to increase.

Program evaluation, combined with the good reputation of its training staff, can result in significant State budget increases for the SSA training offices. Through the collection and analysis of training data, alliances and cooperation with other State agencies, particularly the health department, can be built. These alliances can also help bring about budgetary increases for training.

Recommendations for Training Delivery Systems

Participants believed that the severity of the AIDS problem demands a strong and effective working partnership between Federal and State authorities, a partnership that could establish strong supportive linkages to local service providers. The participants offered the following recommendations for developing and maintaining a State system for AIDS training.

- There is a need to establish a new national substance abuse and AIDS training system that will develop high-quality courses, skilled trainers, Federal-State coordination, and local training capacity. This system need not be a program in the sense of a mandated or specifically funded entity, but it must be a strategy

and process that is both observable and predictable. It must also be a leaner and more cost-efficient organization than the NIDA training system of a decade ago, reducing labor-intensive services and the tendency toward centralized training. That is, it will need to explore cost-effective approaches for reaching workers and programs in their local and State environments, using electronic mail and other communications technology to print, transmit, update, and even conduct some forms of training.

- To support the tremendous demand for technology transfer, NIDA must continue to expand its efforts in trainer development, setting standards, and certification criteria, and maintaining a trainer registry. This program must be streamlined, easy to implement, and computer supported.
- A standardized, individualized pretraining assessment questionnaire needs to be developed. Information on course participants would allow trainers to examine their pretraining assumptions and modify or fine-tune delivery plans. This information would provide a basis for outcome evaluation, also.
- States need to learn the lesson from what happened to NTS: We cannot depend on a healthy, growing State training system based on public funds. States need to build the capacity for an open, competitive trainer market. This self-sustaining system would combine centralized State resources, trainee fees, trainee slots, and purchased consultant, university, or commercial training services.

4. DEVELOPING AIDS TRAINERS

The substance abuse trainers of the 1960s were paraprofessionals, grassroots clinicians in the world of licensed and degreed medical and mental health practitioners. Although the first trainers included some nurses and other dedicated professionals who worked with addicts, being a recovering addict was considered the ideal prerequisite for being a good trainer.

By the mid-1970s, a more scientifically grounded understanding of abuse and addiction had developed, based on study of human metabolic function, brain chemistry, and behavior in family and social systems. This knowledge base served to ground and professionalize the status of the substance abuse trainer. NTS further supported and enhanced the role, producing a national cadre of experienced, committed professionals who staffed and trained the immense work force that mounted the national drug treatment program throughout the 1970s. Trainers had gained both social stature and professional recognition. By the early 1980s, substance abuse trainers had developed credibility.

Status of AIDS Trainer Development

Trainer development has taken on a new urgency in the age of AIDS. Participants reported a severe shortage of qualified trainers capable of integrating AIDS material in substance abuse training. Many experienced substance abuse trainers left the field during the 1980s, partly because of cutbacks in training positions within the SSAs.

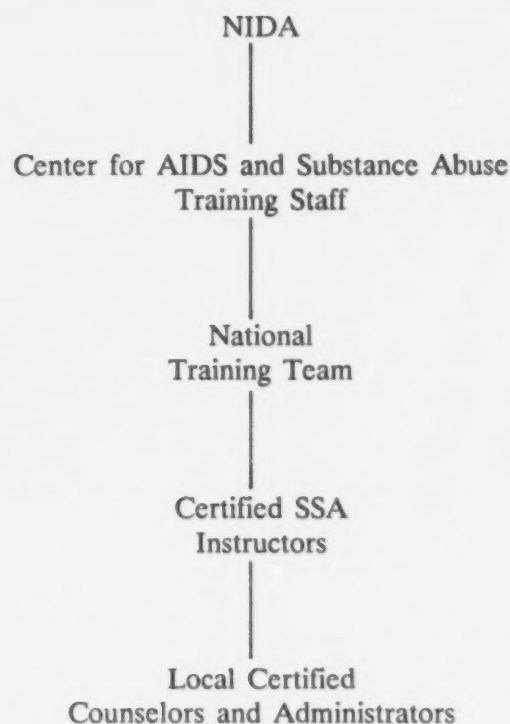
The combination of skills and experience required of AIDS and substance abuse trainers is not easy to find. According to the conference participants,

- The trainer's skills should be developed and tested before the trainer conducts AIDS training.
- Experience with the drug abuse field and a capacity for developing relationships with drug users are fundamental traits for an effective AIDS trainer.
- To conduct training on death and dying and human sexuality, trainers need substantive life experience and maturity.
- The ability to communicate sensitively with trainees from different cultural, racial, and ethnic backgrounds is critical.
- Trainers must be able to work effectively as teams.

Participants were unwilling to compromise these requirements. Although no one trainer is expected to exemplify all the characteristics, any certification process should examine indicators for each. Experience at The Center and at TOI workshops suggests that perhaps only one out of every three paper-qualified candidates is a good prospect for certification and full-scale training.

Trainer certification is a critical component of a training strategy. The Center is designing and implementing a NIDA certification program. The ultimate goal of this program is to ensure that drug treatment staff throughout the country are prepared to deliver AIDS prevention and intervention services to their clients. The more specific, short-term objective is to train and certify a national and State body of AIDS and substance abuse trainers capable of delivering standardized, high-quality AIDS training to programs throughout the country.

NIDA's training strategy is called the "Certification Pyramid." Initially, investment of training resources is limited and focused, with increasingly broader dissemination of certification. This pyramid has five tiers with increasing extension, as depicted in the following diagram:



Trainers from The Center, the National training team, and SSA instructors in the top three tiers will earn NIDA certification on satisfactory completion of each TOI. Local treatment personnel in level four will be certified based on certification processes worked out by each State, using the NIDA model.

Although the TOI model assumes that trainees possess the basic training skills, results of TOI trainings suggest that some participants in the AIDS and IV Drug User course did not grasp all the elements needed to conduct AIDS training. There is a continuing need for ongoing training in adult learning theory, trainer interventions, small-group processes, co-training, and active listening and feedback skills. The trainer certification program will need to address this issue and assure that performance competency in all these areas is a condition of certification. Some participants recommended reinstituting generic TOI courses designed to prepare and certify trainers in the knowledge base and skills required for all trainers.

Needs and Gaps in the AIDS Trainer Development

Participants kept returning to several issues they believed especially important to developing successful AIDS trainers:

- Trainers need more formal specification on how, when, and where to use team training. Team training is probably essential for most AIDS-related trainings, given the wide range of content and trainer skills needed. Instruction in team training is particularly critical for substance abuse trainers who must team with medical and other health professionals in workshops.
- Mastery must be the goal in developing both AIDS and non-AIDS trainers. Although the urgency of the AIDS crisis works against mastery of training curriculums, the need to coach trainers toward professional competence is paramount.
- Current TOI models generated from the NIDA curriculum need to be developed further to support trainer mastery. As more issue-specific AIDS training courses are developed, trainer mastery may require up to five steps of training: generic TOI, specific course training, specific TOI, supervised co-training, and lead trainer with multicourse competency.

Some participants trained in the NTS program suggested there is a need to update and reissue NIDA's generic TOI course (phase II). These participants said current TOI is too course-specific for new AIDS trainers, who need indepth grounding in basic trainer skills and knowledge.

Participants cited the growing need to use medical and other health professionals as co-trainers or consultants. For many trainers, this use of "outsiders" causes resistance and frustration. The resistance appears to be associated with differences in the professional cultures of substance abuse workers and health experts, who come from a more academic, science-based environment. Substance abuse trainers need support to integrate and work through their resistance so they do not reject critical clinical and epidemiological expertise.

Trainees who lack hands-on experience and knowledge of substance abuse, even if highly qualified, rarely seem to become excellent AIDS and substance abuse trainers. Few develop sufficient knowledge to answer specific questions on treatment planning, case management, and prevention issues. They are unable to bring to the training workshop any direct experience working with IVDUs, prostitutes, adolescents, or the community. Many also have difficulty conducting training courses that utilize role play and exercises involving counselor skills.

In this AIDS crisis, participants underscored the need for trainers who understand the IVDU population and multicultural and community issues. Efforts to recruit trainers should target the trained substance abuse experts currently in the field.

The demand for and upon AIDS trainers is relentless, and burnout is a noticeable problem. The request for AIDS training at every level is unceasing, and, more important, the cultural and value conflicts, anxieties, and rapidly increasing knowledge about AIDS exert extraordinary demands on the trainer. Keeping up in the field is a high and noble ideal, yet it remains the goal of many AIDS trainers.

Evaluation of AIDS Trainer Development

Participants made the following suggestions for evaluating AIDS trainers and the training programs that prepare them:

- Training participants could fill out postworkshop questionnaires to rate the knowledge and skills of the trainers and recommend changes in the course and training team. Through followup surveys, trainers could provide information on whether they are using the skills learned through TOIs.
- The lead training agency could conduct onsite monitoring to provide trainers with feedback and to note remedial training needs. Lead trainers could debrief each training team and present written reports to the lead agency.

Recommendations for AIDS Trainer Development

To assure a strong AIDS prevention capability in the country's drug treatment programs, participants suggested that the national program of AIDS certification be linked to funding for drug abuse treatment and training. Federal and State funds would be granted according to a State's or program's ability to demonstrate that a plan is in effect to train and certify all treatment personnel on AIDS issues.

This linkage of funding with certification would, in turn, drive dissemination of AIDS training in each State and region. It would be in the State's and local program's interests to secure training and certification for staff expeditiously and continuously.

Participants made the following recommendations for developing AIDS trainers:

- NIDA's generic TOI course (phases I-III), or a similar course, needs to be reissued and updated.
- Minority trainers need to be identified and enrolled in the fight against AIDS and substance abuse. HIV risk assessment, risk reduction counseling, and AIDS disease management call for cultural sensitivities that minority trainers have. At present, although their numbers are increasing, too few black, Hispanic, and Native American trainers are being prepared for the long effort in AIDS prevention.

CHAPTER IV: EMERGENT THEMES AND NIDA ACTIVITIES

Three underlying themes of concern and commitment appeared to propel the participants' discussion. These themes are important for what they reveal about the possibilities for change in substance abuse training at the beginning of the 1990s. These themes also represent the underpinnings of NIDA's training activities.

THEME ONE: NEED TO PROFESSIONALIZE THE CHEMICAL DEPENDENCY WORK FORCE

The HIV epidemic has affected substance abuse treatment and prevention in the United States deeply, and tremendous expectations are being placed on the Nation's substance abuse professionals. Counselors, supervisors, and directors alike have the responsibility for preventing the spread of HIV and slowing the incidence of AIDS in drug-using populations in every major city. These workers are also the frontline workers in the longstanding national war on drugs.

Yet public support for training and education for substance abuse workers declined steadily over the past decade. Therefore, we need a national commitment to revitalize programs, sustain remedial training, and develop a first-class professional work force in chemical dependency and AIDS prevention.

THEME TWO: FEDERAL-STATE PARTNERSHIPS

A Federal-State partnership in AIDS and substance abuse training is emerging. This partnership is taking a capacity-building approach and will play a critical role in transferring AIDS prevention technology to every substance abuse program and worker in the country. A series of initiatives developed by NIDA staff and supported through contract funds has produced a rich array of achievements: design and implementation of a systematic, comprehensive training system; development of a prototype model for training delivery based on a TOI approach; dissemination of AIDS training to more than 20,000 workers; initiation of technical assistance to States to develop AIDS training plans; implementation of a trainer certification process; support to develop and certify a national team of master trainers and certified state instructors; and support for The Center for AIDS and Substance Abuse Training, a resource center charged to develop, integrate, and disseminate to the States the most advanced knowledge, skills, and training technology.

Federal leadership notwithstanding, it is clear that the battle against AIDS in the drug-using population will be fought and won at the level of the local community. Sustained maintenance of local training capacity and steady transfer of Federal training resources to SSA training programs will be essential throughout the coming decade.

THEME THREE: MATURING OF TRAINING LEADERSHIP

The AIDS crisis has revealed and strengthened a maturity in the training leadership in the substance abuse field. This maturity was revealed in the participants' many clear and powerful statements of professional and personal commitment. Trainers have already spent many overtime days and hours preparing themselves with new knowledge and skills and enrolling colleagues, program directors, and entire communities in the fight against AIDS. The maturity of the training leadership is manifested also in the new alliances it has forged with non-drug treatment professionals and other State health and medical organizations; in the planning required to develop training programs; and in the work to secure State funds for substance abuse training.

NIDA'S CURRENT ACTIVITIES

Based on the meeting of AIDS educators and NIDA's experience in the field, NIDA is expanding its AIDS training activities. New activities include the following:

- Introduction of a generic training course to help potential trainers develop basic training skills
- Development of AIDS training internships in substance abuse programs for graduate students in human services (i.e., social work, psychology, public health)
- A special study to examine the feasibility of using case management in substance abuse programs that serve HIV-infected clients or clients at risk of HIV infection
- Special training for supervisors of outreach workers
- Development of modules for training methadone workers
- Expansion of cultural sensitivity training for workers who serve Hispanic women and blacks
- Expansion of training for staff serving adolescents and incorporation of a special skills training course on AIDS for adolescents themselves
- Continuation and expansion of technical assistance to States to develop AIDS training plans and build AIDS training capabilities
- Expansion of NIDA's national training teams, with special efforts to include more minorities

- Continuation and expansion of training for outreach workers
- Development of additional training modules as needed
- A meeting of State coordinators for AIDS training in the fall of 1990 to follow up the educators meeting, discuss State experiences, and form coalitions

Through its activities NIDA is in the forefront of propelling the training field forward, attempting to cover ground lost when NTS was dismantled in 1981. NIDA AIDS training activities have been an impetus for both the Federal and State governments to examine chemical dependency training in general. Through future training activities in the 1990s, it is anticipated that Federal-State partnerships will grow and the chemical dependency work force will become professionalized.

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